Philip N. Hodge, DDS, PS

19221 108th Avenue SE, Ste. 4 • Renton, WA 98055 • (253) 852-4746 tel • (253) 852-4754 fax

Welcome to our office. We appreciate the confidence you place with us to provide dental service. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

PATIENT'S NAME _____ Date _____

Preferred Name _____ Sex ❑ F ❑ M

❑ Married ❑ Single ❑ Other _____

Birthdate _____

Mailing Address _____

City/State _____ Zip _____

Home Phone _____ Cell _____

Employer _____ Work Phone _____ Ext # _____

❑ Email _____

Soc. Security No. _____

Patient Occupation _____

How can we best reach you? ❑ Cell ❑ Pager ❑ Work ❑ Home

Time of Day _____ ❑ AM ❑ PM

Name of Spouse _____

Birthdate _____

Cell _____

Work Phone _____ Ext # _____

Soc. Security No. _____

Occupation _____

Employer _____

Names of children living at home:

Name	Birthdate

Previous Dentist's Name _____ Telephone # _____

Whom may we thank for referring you? _____

PRIMARY DENTAL INSURANCE

Employee _____

Employer _____

Insurance Co. _____ Group# _____

Phone No. _____

Insurance ID No. _____

SECONDARY DENTAL INSURANCE

Employee _____

Employer _____

Insurance Co. _____ Group# _____

Phone No. _____

Insurance ID No. _____

Person responsible for payment: _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Hm Phone No. _____ Wk Phone No. _____

Relationship to Patient _____

Physician's Name _____ Phone No. _____

DENTAL HEALTH HISTORY

Patient's Name _____

Please mark any that apply:

	Y	N
Are you apprehensive about dental treatment?	❑	❑
If so, what is your biggest concern? _____		
Have you had problems with previous dental treatment?	❑	❑
If so, please describe. _____		
Do you gag easily?	❑	❑
Do your gums bleed or hurt when you brush or floss?	❑	❑
How often do you brush? _____		
How often do you floss? _____		

	Y	N
Do you clench or grind your teeth while awake / asleep?	❑	❑
Do you have clicking or popping when opening or closing?	❑	❑
Do you have pain of joint, ear, or side of face?	❑	❑
Do you feel pain when your teeth come in contact with:		
Hot foods or liquids?	❑	❑
Cold foods or liquids?	❑	❑
Sweets?	❑	❑
Do you experience chewing sensitivity?	❑	❑
Does food catch between your teeth?	❑	❑

MEDICAL HEALTH HISTORY

Do you have, or have you had, any of the following:

	Y	N
Heart Problems	❑	❑
Chest pain	❑	❑
Shortness of breath	❑	❑
Blood pressure problem	❑	❑
Heart murmur	❑	❑
Heart Attack	❑	❑
Heart valve problem	❑	❑
Taking heart medication	❑	❑
Rheumatic fever	❑	❑
Pacemaker	❑	❑
Artificial heart valve	❑	❑
Blood Problems	❑	❑
Abnormal bleeding	❑	❑
Blood disease (anemia)	❑	❑
Allergy Problems	❑	❑
Hay fever	❑	❑
Sinus problems	❑	❑
Skin rashes	❑	❑
Taking allergy medication	❑	❑
Asthma	❑	❑

	Y	N
Intestinal Problems	❑	❑
Ulcers	❑	❑
Weight gain or loss	❑	❑
Kidney or bladder problems	❑	❑
Bone or Joint Problems	❑	❑
Arthritis	❑	❑
Back or neck pain	❑	❑
Joint replacement	❑	❑
(e.g, total hip, pins, or implants)		
Fainting Spells, Seizures, or Epilepsy	❑	❑
Stroke(s)	❑	❑
Frequent or severe headaches	❑	❑
Thyroid problems	❑	❑
Persistent cough or swollen glands	❑	❑
Premedications required by physician	❑	❑
Cancer/Tumor	❑	❑
Tuberculosis or other respiratory disease	❑	❑
Do you smoke?	❑	❑
If so, how much? _____		

	Y	N
Diabetes	❑	❑
Urinate more than 6 times a day	❑	❑
Thirsty or mouth is dry much of the time	❑	❑
Family history of diabetes	❑	❑
Hepatitis, jaundice, or liver trouble	❑	❑
Herpes or other STD	❑	❑
HIV-positive/AIDS	❑	❑
Glaucoma	❑	❑
Do you wear contact lenses?	❑	❑
History of head injury?	❑	❑
Epilepsy or other neurological disease?	❑	❑
History of alcohol or drug abuse?	❑	❑

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe _____

_____

Are you allergic, or have you reacted adversely, to any of the following?

	Y	N
Local anesthetics ("Novocaine")	❑	❑
Penicillin or other antibiotics	❑	❑
Sulfa drugs	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑
Aspirin, Acetaminophen, or Ibuprofen	❑	❑
Codeine, Demerol, or other narcotics	❑	❑
Reaction to metals	❑	❑
Latex or rubber dam	❑	❑

Other _____

Notes: _____

_____

_____

Women

	Y	N
Are you taking contraceptives or other hormones?	❑	❑
Are you pregnant?	❑	❑
If so, expected delivery date: _____		
Are you nursing?	❑	❑

Current list of medications & Dosage:

_____

_____

_____

_____

_____

_____

During the past 12 months, have you taken any of the following?

	Y	N
Antibiotics or sulfa drugs	❑	❑
Anticoagulants (e.g., Coumadin)	❑	❑
High blood pressure medicine	❑	❑
Osteoporosis medication	❑	❑
Tranquilizers	❑	❑
Insulin, Orinase, or similar drug	❑	❑
Aspirin (daily)	❑	❑
Digitalis or drugs for heart trouble	❑	❑
Nitroglycerin	❑	❑
Cortisone (steroids)	❑	❑
Natural remedies	❑	❑
Nonprescription drug/supplements	❑	❑

Other _____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize Dr. Hodge and/or dental staff to perform all necessary dental services that I may need. I understand that I am responsible for payment of services rendered and also responsible for paying any unpaid portion that my insurance does not cover.

Signature _____ Date _____

Notes: _____

Comments:

Philip N. Hodge, DDS, PS

The Fine Art of Dentistry

- Patient Financial Policy -

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable we are pleased to offer you the following payment options. Please select one.

1. Cash, Check, Debit
2. Visa, MasterCard, Discover, American Express
3. Payment Plan

We will, as a courtesy, process your insurance benefits in our office. Specific questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received. One percent (1%) per month interest, twelve percent (12) per year will be charged on accounts 90 days from treatment date. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

Please make your questions and concerns known to our Accounts Manager who is happy to discuss this policy and ensure that you have an outstanding experience.

Signature (responsible party) Date

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info@drphilhodge.com ~ www.drphilhodge.com

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Philip N. Hodge, DDS, PS
19221 108th Ave. SE Suite 4
Renton, WA 98055
253-852-4746

My Signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ❑ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ❑ Obtain payment from third-party payers for my health care services
- ❑ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that your are not required to agree to my requested restrictions, but if you do agree then your are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ❑ The patient refused to sign
- ❑ Communication barriers
- ❑ Emergency situation
- ❑ Other